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MILITARY PSYCHIATRY NUMBER, III

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Bulletin of
THE MENNINGER CLINIC

VOLUME 8 March, 1944 NUMBER 2

A BRIEF IMPRESSION OF BRITISH MILITARY PSYCHIATRY

BY BRIGADIER J. R. REES

Consulting Psychiatrist to the Army, RAMC

With so many facts and observations of interesting and brilliant bits of work seen on this trip to the United States Army and to Canada still to be digested and assimilated, it is not easy to pick out those points which may be of the greatest value to you. I am going to touch, therefore, too briefly I am afraid, on some aspects of our four years' experience in the British Army, and leave the amplification of any of these matters which interests you to further discussion.

THE IMPORTANCE OF PSYCHIATRY IN WAR

In war-time many of us have come up against the needs and interests of the *group*, as opposed to the needs of the *individual* which have been our main concern in civil practice, for the first time in our lives. We find ourselves having to consider manpower, the strengths of Armies, and consequently the wastage. Malaria may well in the future be the greatest cause of wastage in all our Armies unless adequate measures can be taken, but up to the present time the big manpower wastage has come from psychiatric disorders, not only in the matter of rejections of men at the selection stage, but in the final discharge rates. We find that in Great Britain some 30 per cent of our total is due to the various psychiatric illnesses and the figures in Canada and the United States are not very dissimilar; we know nothing definite about Germany or Russia. This is consequently a very serious problem for every Army and an equally grave problem for the countries concerned. At the end of the last war we in Great Britain had over 100,000 men who were pensioned on psychiatric grounds, and I would remind you that in World War I only those cases where diagnoses were very obvious were listed as psychiatric disabilities. Many psychosomatic conditions masqueraded and finally drew their pensions under the names of a variety of physical disorders.

The Army at home has been my main interest throughout the War, and there we have had to deal with grand fellows, but also with many problems, since the Royal Navy and the Royal Air Force and even the Civil Defence services have had their pick of men before the Army did. Our manpower

situation is difficult, and consequently we have had to take in a great many men whom you in the United States would have cut out or tried to cut out through your selection procedures, and later on we have had to discharge them. True battle neurosis has not been, until recently, a very serious problem. It is true that in Norway some 33 per cent of the admissions to certain of the General Hospitals were cases of anxiety neurosis, or at any rate disabling conditions of anxiety. In France there was comparatively little fighting and, therefore, not much war neurosis until the "Dunkirk" evacuation. There arose at that time, quite understandably, a good deal of serious anxiety. Many of these men carried on when they got back to the United Kingdom but broke down later at their work, and we are still picking up from various quarters cases of what we call post-Dunkirk conditions. In the Libyan campaign there was very little breakdown of any kind. Up to Bengazi in the first expedition there were under 100 cases of battle neurosis in the three Services combined. That is understandable because it was a rapid-action, winning war, and there was no undue mental fatigue even if there was physical fatigue. With the alteration of the character of the war we have found in the Tunisian fighting a very much higher incidence of neuroses. Whereas the earlier rate was about 2 per cent of all casualties it has recently risen to 10 per cent or 15 per cent, and that is in fact the figure for which it is wise to budget. Where you have troops who are inexperienced as with the United States Army at first, the figure will be higher than that. It would appear that we have here also a very serious source of manpower wastage.

A PSYCHIATRIC VIEWPOINT

It comes about, therefore, that in the Services psychiatry is not just a specialty—although there must always be specialists in psychiatry, just as there are in surgery or internal medicine—but in the Army where we are considering the group it is essential that every medical man should have a psychiatric point of view and be thinking at all times in terms of the man himself and the group in which he works. This is true whether we are internists, surgeons, psychiatrists or indeed carrying out any other job in the Medical Corps, and that is the first point that I would like to stress to you. Napoleon in one of his letters wrote, "In War the spiritual is to the material as three to one." That is probably as true of civil life as of war but it is certainly true for us now and however good our equipment and all the material factors, nothing can win the war save the spirit, the mental health and morale of the men and women in the Forces.

SOME OF THE TECHNIQUES IN THE ARMY

With the Army at home because of the shortage of men and the constant necessary changes in policy and emphasis on manpower we have had to

devise many methods of using men who can only be of limited service. Our men breaking down with psychoses, in practically every case, go out of the Army. It is perhaps of some interest to record that in Britain we have been allowed to keep our psychotics in the service in Military Hospitals for six or even nine months if they are responding to active treatment. As a result only 5 per cent of all the men and women with psychotic conditions have had to be certified on discharge from the Army. They may turn out in the long run to be a demonstration of the value of active treatment at a very early stage. We have a follow-up inquiry going on which will continue for ten years after the war. Our men who are defective or dull and backward have been a considerable problem, but we have relearned in this war what the United States taught us in the last war that our worst soldiers are our best diggers. In most cases our dull men are transferred to the Pioneer Corps for heavy labouring work of many kinds, and very dull men who are not to be trusted with lethal weapons at all serve in the unarmed sections of the Pioneer Corps. With good Officers and N.C.O.'s these sections are magnificent. The men are proud to be in the Army and in uniform they become smart. They sing at their work and at their meals, have done quite unheard of feats of work, and respond to any crisis needs such as the embarkation of the North African forces. Whereas they were problems in their units with long crime sheets and constant attendance at sick parade, the unarmed Pioneers have less sickness and less crime than good units of the Field Force. Furthermore, there are no sexual difficulties and this is a point of sociological interest since this is the group of men who in civil life lead lonely and generally unhappy lives. The man finds some woman, usually herself defective, whom he marries or lives with, and the result is a large family of defective children. It would seem to me that if this type of operation could be carried over into civil life we could do a great deal more than can be done by sterilization of the mentally defective.

The chronic psychoneurotic group have been a headache to us—men and women with heavy predisposition, a history of childhood difficulties and psychosomatic troubles in adolescence and usually with poor employment histories. Many of these have had to go out of the Army, back to civilian niches where they could adjust their lives and carry on in other forms of work of national importance. Fortunately there is no unemployment in England. We have, however, devised schemes for special posting for many of these men where it is felt by the doctor who has seen them in a hospital that they could continue to give good service in the Army in some job which fitted to their pre-war employment, interests or hobbies. Many thousands of men have been so employed in special postings and some 50 per cent of them have shown that they could carry on and give good efficient service without breaking down.

These are just some indications of the methods we have had to devise. They serve to demonstrate convincingly that if you can put the inadequate man into work that is within his competence he may give very valuable service to the group. This is obviously a matter of great importance both to the Army and to the individual who is concerned.

PRIORITIES

This brings me to speak of priorities because they must exist in our medical thinking just as in other fields. We have put treatment rather low in the list because the number of men who are brought back to military service by treatment is small and it is far more important to keep men well and thus maintain the efficiency of the Army. Selection, therefore, has always been our first priority because if you can select your men and really fit square pegs to square holes then you not only are increasing the efficiency of the Force, but you are doing preventive medicine of high order. Men who are happy and feel that they can do their job are likely to be very much better trained, and in consequence the morale difficulties that they might otherwise meet are avoided.

Our selection process for men is not very different from that employed in Canada and the United States, though there are certain differences in administration. The Ministry of Labour does the preliminary medical boarding with the Civilian Neuropsychiatry Board, and the Army has now arranged that when the men come in first for their basic training they go through a whole battery of tests for intelligence and aptitude. The selection of men has justified itself in scores of different ways. It was interesting to find not long ago in Tunisia that one particular Armoured Division which had been carefully selected not only gave outstandingly good service but also showed practically no psychiatric breakdowns of any kind, in strong contrast to certain other groups which were known to have been rather poorly selected.

We have gone farther than the ordinary selection procedure and have developed Officer Selection. The statement, "There are no bad soldiers, only bad officers" is probably true and we were faced by the fact that many of our officers chosen in a hurry were not turning out to be as good as we would like. The man who could sell himself easily did so when there was only a single interview before he was sent to the Officer Cadet Training Unit, and many of them who were rather diffident or shy were turned down even though they might ultimately have become first class officers. We devised a scheme therefore by which candidates came up and stayed for two or three days, working with a team of line officers, psychiatrists and psychologists. The psychiatric interview is probably the crucial point of the whole procedure, but the other interviews and the various situational

tests which the man goes through help greatly in the assessment of his character and his officer qualities. There is no doubt whatever about the success of this work which is now being carried on all over Great Britain and abroad in Africa, Italy and India. Better men are being picked, the wastage rate is being cut down, and the morale of the Army as a whole has benefitted from what is recognized to be a democratic and fair procedure. Since my interest is always to some extent on the future, after the present war has been settled, I would point out that these two types of selection, one for the larger groups in industry and the second for specialist types, are capable in all our countries of application to civil groups and with some modifications might go far as Preventive Medicine if we can handle the matter wisely.

A WIDE FIELD

Because of the needs of the group we psychiatrists have naturally gone on from selection where we are working with personnel officers, industrial psychologists and others to help where possible in problems of training. Battle inoculation if properly employed is a most valuable prophylactic against breakdown and stress in troops when they actually arrive in combat. Many of the other training activities need such help as we can give them from our knowledge as doctors and psychiatrists, and in a variety of ways it has been possible to help in the planning of various training tactics and procedures. The morale of men depends largely upon their being well trained, since pride in one's technical skill is a fundamental element of good morale. You and I have as our special skill our competence as officers to lead men and to play our part as soldiers and quite secondarily our skills in medicine acquired through many years. Our pride and confidence in these roles is what gives us good morale. Similarly, every man who has to learn a new technique must be well trained if he is to be a satisfactory and happy member of a group doing a definite job overseas. This war cannot be fought with ill-trained or inadequate men. The speed and tempo, and mechanization of the tactics of modern warfare demand high intelligence and very considerable stability and in this there is a considerable difference from any other war that has gone before.

Where the morale of a Unit is high and its officer-man relationships are good, i.e., good welfare, good leadership, good discipline, there you will have very much less tendency to break down under battle stress. That has been shown very clearly by the Eighth Army which perhaps stands in a unique position as an illustration of high group morale. The Eighth Army was so sure of itself, so confident and so much a family that the fact that one belonged to the Eighth Army was of tremendous value in the therapy of such breakdowns as occurred and more important, as a preventative of

breakdown. In fact, of over 1400 cases of battle neuroses arising in the recent Tunisian fighting only 2 per cent were evacuated from the Eighth Army to the Base and the rest were back on full duty of some kind within their own Army within six weeks.

BATTLE NEUROSIS

It must be recognized that any man, however good his constitution and background, however good his intelligence, and however sound his training, *may* break down during action. Granted that with the fatigue that follows several nights without proper sleep, with inadequate feeding and with the stresses that are incidental to battle, any man may find himself breaking down after long bombardment by artillery, by trench mortars or dive bombing. When I was recently in Algiers I saw in a hospital eight officers with battle neurosis who had recently been decorated for gallantry on the field, and seven officers who had been instructors in battle schools. This observation is cited merely to show what most of us realize is the truth, that to develop a battle neurosis is not an indication of a poor or weakly man. Naturally the inadequate man will in many cases have less resistance than the adequate one and so one would expect him to break sooner, but the development of true neurosis is something which we must anticipate in any group of men under continual stress. We can do much in the matter of prophylaxis on the purely mental side if as a profession we would stress, on every suitable occasion, the idea that fear is universal, not something to be ashamed of, and that it is quite different from cowardice. The man who is ashamed of experiencing fear is much more likely to mishandle his emotional difficulties in war and so break down. We must encourage people to come to terms with and make friends with their own fears. Everyone of us who may be faced with conditions of enemy action has to watch very carefully for signs of stress in individuals with whom we are concerned or in the group for which we may be responsible. Increasing restlessness, loss of attention, amnesia, change in mood or personality may all be indications that the man concerned is getting near the breaking point and we must, wherever possible, ensure that men do not reach that point and crack. It is of little use waiting until they actually become casualties. When men or officers do break down and have to be sent down the line we have now learned by experience that they should go down with adequate sedation, sufficient to prevent the anxiety becoming conditioned, and that this simple measure improves the chances of treatment very greatly. Rest stations are being established behind the lines in every battle zone; and the man sent down is normally labelled "exhaustion." If he recovers after a day or two and gets back to the line he has no need of a further

diagnosis. If he has to go further back, the correct diagnostic label is attached by the doctors who see him at the Rest Station.

It has been shown in Tunisia and again in Italy that when active treatment for these men was given near the front line, some 60 per cent or more were returned to full combat duty, thus maintaining the manpower and efficiency of the fighting forces. I have little doubt that in the long run it is the soundest therapeutic procedure for that stage. The cardinal rules for handling these cases on the physical side are "rest, feed and purge." Sedation must be given with enough of one of the barbiturates to ensure that the man will have sleep if he lies down, though he can be up several times each day and carry on ordinarily. He must have some degree of security and that can generally be arranged a few miles behind the line.

Simple psychological treatment consists generally in getting the man to abreact his emotional experiences, talking them out very fully and in the present tense, reliving all the horrors and conflicts through which he has gone. This entails considerable active participation on the part of the doctor who is helping him. It is almost like acting in a play to get the man really to relive his experiences and not discuss them in a detached way. Having by this process of psycho-catharsis or psychosynthesis cleared much of the background material, some simple re-educative talks about the man's own attitude to his fear and responsibilities with a little friendly persuasion and kindly firmness will, after a day or two of rest, enable him to get back to full duty in the line. This cannot of course apply to those men who have a psychopathic history, those men who are very unwilling to go back into the line, or those in whom there is any evidence of blast injury or other trauma.

These methods of active treatment are probably pretty well known to you and are available in writing, especially in Lieut. Colonel Grinker's recent paper, published by the Josiah Macy, Jr. Foundation of New York.

I would like to emphasize that it is essential to everyone of us to understand and know how to deal with these conditions which any of us may meet. We have depended upon the physicians and surgeons for much of the active treatment at the front and we shall continue to do that.

Finally, I would like to emphasize again my opinion that our primary responsibility is to the group more than to the individual. We can do much in human medicine, or social psychiatry—call it what you like—but our primary interest must be concern for the Army and its present purposes, and ultimately to make use for society of all the techniques and experience that we have been able to acquire in this war, at home or overseas.

SOME FACTORS IN THE HIGH RATE OF NEUROPSYCHIATRIC CASUALTIES*

By BRIGADIER G. B. CHISHOLM, D. G. M.S., Canadian Army

In considering the causes of the very high rate of psychiatric casualties in both American and British Forces during recent months' fighting in the Middle East, it is not satisfactory to pass this very important question off casually as the result of deprivation or disease or exhaustion. Other armies throughout history have suffered far more acutely in all these fields than have any large numbers of our troops in the Middle East. In the Napoleonic and Peninsular Wars, for example, deprivation, disease and exhaustion killed large numbers of men; that has not happened in this war. It is true that in relatively recent years high explosives have been added but it is now quite clear that any concussion from explosions has rarely been an important factor in these disabilities, and it is not to be supposed that the prospect of being blown to bits by a high explosive shell or mine or bomb is any more terrible than the expectation of being scalped by Indians or tortured as was the expectation of many fighting men throughout history. Neither is it satisfactory to postulate such a mystical concept as a "weakening of moral fibre," whatever that may mean. It simply does not explain anything.

There must of course be a reason or reasons why our armies, and particularly the armies of the English-speaking nations, are failing in such large numbers to stand up emotionally to continued warfare. Reasonably reliable evidence indicates that these types of disabilities have not been a great problem in the German nor in the Russian armies. So far as I know of there is no great evidence that this same problem has been extensive in the Italian army. We have no information about the Japanese army.

It is quite clear that the fault in our soldiers is in their handling of the emotion of fear, and to find the reason why they are being more affected than are soldiers of other nations, we should examine the development of our people in relation to fear compared with that of the peoples of other nations. It is obvious that in both Germany and Russia human life and human comfort are regarded generally as far less important than they are in our English-speaking nations. The punishment of political offenses by death for instance has been, in both these countries, rather common and still is. It is a very long time since anything of the kind has happened in English-speaking countries. We find too that in both Germany and Russia the welfare of the individual is regarded as of no importance com-

*Discussion at Psychiatric Panel, Association of Military Surgeons of the United States, Philadelphia, October 22, 1943.

pared with the good of the State, whereas in English-speaking countries the welfare and rights of the individual are extensively protected against the encroachments of Government. It is obvious that development throughout childhood and youth in these widely divergent systems will have, and has had, a considerable influence on the attitudes of their citizens about their own security and its relative importance.

It seems probable however that this is not the main factor in our soldiers' relative inability to "take it." If we examine attitudes in the homes in which our children have been brought up we find that during the last twenty years or so an enormous importance has been given to personal safety. During these same years Germans have been brought up to "live dangerously" and Russians to devote their lives to the State. A whole generation of English-speaking peoples has been brought up under the slogan of "Safety First" which has become a high moral principle throughout our civilization. Responsibility to parents for the integrity of the child's own skin has been inculcated in the conscience of almost every child as a first moral principle. The "baddest" child is the child who takes any chances of getting hurt.

At the same time our children are surrounded by very many restrictions in the field of social behavior; to hurt other people or even to want to hurt other people is strongly disapproved and is experienced by children as very bad. We have in fact brought up a generation specifically trained to repress aggression and not to be able to fight. They have been taught to abhor their own aggressive urges and to be ashamed of and repress their desires to hurt or kill. While there are many arguments for the desirability of "safety first" campaigns in terms of comfort and security it is quite obvious that this slogan should not be given the position of a first moral principle. The whole fact of the English-speaking peoples being in this war is a negation of this principle. We would all be perfectly safe if we stayed home and allowed the Germans or Japanese to look after us. They would require only absolute obedience. We have taught children that safety comes first, but in getting into this war we demonstrated that the principles that were made important throughout their development are found now to be untrue.

Our young recruit comes into military training loaded down with the moral principles under which he was brought up. We expect him then of his own volition to undertake responsibilities and place himself for the sake of a cause in positions which may well mean the loss of his own life. We also expect him freely to kill other men because of a social expediency. It is not surprising that on both these scores our young soldier is in trouble. The violation of his conscience values will naturally produce feelings of guilt and fear.

At the same time fear itself has been tabooed in childhood. Any expression of fear has usually been strongly disapproved by parents. The effect on our soldier is to make him afraid to admit fear because it is experienced as a shameful thing. It is apparent from reports of Colonel Grinker and others from the Middle East that these disabled soldiers are suffering from the repression of fear. There is plentiful evidence to assure us with reasonable certainty that no man can panic or break down in an anxiety or hysterical state as the result of contemporary fear—the fear of the present situation alone. These men who break down have been "saving up" their fear. They have been carrying large volumes of unexperienced fear below the level of consciousness. They have always shown signs of increased tension for some time before they break. At a threshold point of such accumulation, which is specific for each man, and will depend on things like his family's attitudes, morale of the unit, the attitudes of officers and N.C.O.'s under whom he trained, as well as degree of exhaustion, deprivation and health, the fear can take charge of the man's behavior, to remove him from an impossible position. The treatment, which is remarkably effective, is to uncover it and to allow it full expression with reassurance and re-education about the normalcy of fear in dangerous situations.

One of the most important functions of military training is to reverse the training already given to our young men in their homes and their communities. Officers and N.C.O's must repair the deficiencies left by parents. It is necessary extensively to reorient their attitudes about their relationship to the group. Most of their previous education has been preoccupied with the responsibility of the State to the individual and with the rights of the individual. To make good soldiers requires extensive re-education. It is important that these necessary new attitudes should not just be overlaid or superimposed on their home training but that the attitudes in which they were brought up should be broken down, and replaced, not just ignored. It is also important that all soldiers in training and throughout training should be introduced to fear and its manifestations and should learn to live with fear as they will have to do throughout the war. It is reasonable to suppose that if 80 or 90% of anxiety states can be got back to selected duty by early treatment close to the front line they can be just as effectively prevented from breaking down by the same type of treatment as a preventive measure.

Fear should be brought out into the open and experienced fully. All troops should learn that the experiencing of fear need never cause a soldier to panic or to avoid a responsibility. Fear must be made respectable and recognized as a benign protective mechanism which prepares the organism for supreme effort.

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MALINGERING; THE SIMULATION OF PSYCHOSIS

BY V. P. OSSIPOV, M.D.*

Malingering belongs properly to the domain of psychiatry, but has been variously regarded. In olden times it was thought that simulation of a psychosis was a simple matter. But Kraepelin and others denied this. The impression has grown that "pure malingering" rarely exists as such; every malingerer is really an unstable person, a psychopath, who by imitating a psychosis merely accentuates his own latent tendencies so that malingering is really pseudo-malingering.

At the present time there is quite an accumulation of literature on this subject. Contradictory opinions exist partly because of different personal experiences and partly because psychiatry itself has undergone changes in its development. I personally believe that the simulation of psychosis for malingering is very uncommon. Malingering in its pure form appears usually in times of great social upheaval when punishments for crimes are very severe or when the situation is such that one's life is threatened. In such periods large numbers of people develop defense reactions by means of which they hope to escape punishment or death. Thus, there were quite a few cases of malingering in the U.S.S.R. during the civil war when banditry was being eliminated and the captured bandits were condemned to death. But in the last few years this type of crime has decreased, although different kinds of criminals such as speculators, embezzlers and swindlers occasionally resort to this type of self-defense.

In the days before the revolution there was malingering to avoid military service; at the present time one hardly ever finds this. On the contrary, the inductees try to conceal their illnesses so that they will not be rejected by the induction boards. This is most common in epilepsy. Many epileptics are sent back to psychiatric hospitals after they have been in the Red Army for a long time.

In this article I shall discuss the most important methods of discovering malingering and the evaluation of the various symptoms. One must take into consideration the fact that psychiatry has developed a great deal in the past 10 or 15 years and for this reason the various forms of malingering

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BATTLE NEUROSIS

It must be recognized that any man, however good his constitution and background, however good his intelligence, and however sound his training, *may* break down during action. Granted that with the fatigue that follows several nights without proper sleep, with inadequate feeding and with the stresses that are incidental to battle, any man may find himself breaking down after long bombardment by artillery, by trench mortars or dive bombing. When I was recently in Algiers I saw in a hospital eight officers with battle neurosis who had recently been decorated for gallantry on the field, and seven officers who had been instructors in battle schools. This observation is cited merely to show what most of us realize is the truth, that to develop a battle neurosis is not an indication of a poor or weakly man. Naturally the inadequate man will in many cases have less resistance than the adequate one and so one would expect him to break sooner, but the development of true neurosis is something which we must anticipate in any group of men under continual stress. We can do much in the matter of prophylaxis on the purely mental side if as a profession we would stress, on every suitable occasion, the idea that fear is universal, not something to be ashamed of, and that it is quite different from cowardice. The man who is ashamed of experiencing fear is much more likely to mishandle his emotional difficulties in war and so break down. We must encourage people to come to terms with and make friends with their own fears. Everyone of us who may be faced with conditions of enemy action has to watch very carefully for signs of stress in individuals with whom we are concerned or in the group for which we may be responsible. Increasing restlessness, loss of attention, amnesia, change in mood or personality may all be indications that the man concerned is getting near the breaking point and we must, wherever possible, ensure that men do not reach that point and crack. It is of little use waiting until they actually become casualties. When men or officers do break down and have to be sent down the line we have now learned by experience that they should go down with adequate sedation, sufficient to prevent the anxiety becoming conditioned, and that this simple measure improves the chances of treatment very greatly. Rest stations are being established behind the lines in every battle zone; and the man sent down is normally labelled "exhaustion." If he recovers after a day or two and gets back to the line he has no need of a further

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By BRIGADIER G. B. CHISHOLM, D. G. M.S., Canadian Army

In considering the causes of the very high rate of psychiatric casualties in both American and British Forces during recent months' fighting in the Middle East, it is not satisfactory to pass this very important question off casually as the result of deprivation or disease or exhaustion. Other armies throughout history have suffered far more acutely in all these fields than have any large numbers of our troops in the Middle East. In the Napoleonic and Peninsular Wars, for example, deprivation, disease and exhaustion killed large numbers of men; that has not happened in this war. It is true that in relatively recent years high explosives have been added but it is now quite clear that any concussion from explosions has rarely been an important factor in these disabilities, and it is not to be supposed that the prospect of being blown to bits by a high explosive shell or mine or bomb is any more terrible than the expectation of being scalped by Indians or tortured as was the expectation of many fighting men throughout history. Neither is it satisfactory to postulate such a mystical concept as a "weakening of moral fibre," whatever that may mean. It simply does not explain anything.

There must of course be a reason or reasons why our armies, and particularly the armies of the English-speaking nations, are failing in such large numbers to stand up emotionally to continued warfare. Reasonably reliable evidence indicates that these types of disabilities have not been a great problem in the German nor in the Russian armies. So far as I know of there is no great evidence that this same problem has been extensive in the Italian army. We have no information about the Japanese army.

It is quite clear that the fault in our soldiers is in their handling of the emotion of fear, and to find the reason why they are being more affected than are soldiers of other nations, we should examine the development of our people in relation to fear compared with that of the peoples of other nations. It is obvious that in both Germany and Russia human life and human comfort are regarded generally as far less important than they are in our English-speaking nations. The punishment of political offenses by death for instance has been, in both these countries, rather common and still is. It is a very long time since anything of the kind has happened in English-speaking countries. We find too that in both Germany and Russia the welfare of the individual is regarded as of no importance com-

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pared with the good of the State, whereas in English-speaking countries the welfare and rights of the individual are extensively protected against the encroachments of Government. It is obvious that development throughout childhood and youth in these widely divergent systems will have, and has had, a considerable influence on the attitudes of their citizens about their own security and its relative importance.

It seems probable however that this is not the main factor in our soldiers' relative inability to "take it." If we examine attitudes in the homes in which our children have been brought up we find that during the last twenty years or so an enormous importance has been given to personal safety. During these same years Germans have been brought up to "live dangerously" and Russians to devote their lives to the State. A whole generation of English-speaking peoples has been brought up under the slogan of "Safety First" which has become a high moral principle throughout our civilization. Responsibility to parents for the integrity of the child's own skin has been inculcated in the conscience of almost every child as a first moral principle. The "baddest" child is the child who takes any chances of getting hurt.

At the same time our children are surrounded by very many restrictions in the field of social behavior; to hurt other people or even to want to hurt other people is strongly disapproved and is experienced by children as very bad. We have in fact brought up a generation specifically trained to repress aggression and not to be able to fight. They have been taught to abhor their own aggressive urges and to be ashamed of and repress their desires to hurt or kill. While there are many arguments for the desirability of "safety first" campaigns in terms of comfort and security it is quite obvious that this slogan should not be given the position of a first moral principle. The whole fact of the English-speaking peoples being in this war is a negation of this principle. We would all be perfectly safe if we stayed home and allowed the Germans or Japanese to look after us. They would require only absolute obedience. We have taught children that safety comes first, but in getting into this war we demonstrated that the principles that were made important throughout their development are found now to be untrue.

Our young recruit comes into military training loaded down with the moral principles under which he was brought up. We expect him then of his own volition to undertake responsibilities and place himself for the sake of a cause in positions which may well mean the loss of his own life. We also expect him freely to kill other men because of a social expediency. It is not surprising that on both these scores our young soldier is in trouble. The violation of his conscience values will naturally produce feelings of guilt and fear.

At the same time fear itself has been tabooed in childhood. Any expression of fear has usually been strongly disapproved by parents. The effect on our soldier is to make him afraid to admit fear because it is experienced as a shameful thing. It is apparent from reports of Colonel Grinker and others from the Middle East that these disabled soldiers are suffering from the repression of fear. There is plentiful evidence to assure us with reasonable certainty that no man can panic or break down in an anxiety or hysterical state as the result of contemporary fear—the fear of the present situation alone. These men who break down have been "saving up" their fear. They have been carrying large volumes of unexperienced fear below the level of consciousness. They have always shown signs of increased tension for some time before they break. At a threshold point of such accumulation, which is specific for each man, and will depend on things like his family's attitudes, morale of the unit, the attitudes of officers and N.C.O.'s under whom he trained, as well as degree of exhaustion, deprivation and health, the fear can take charge of the man's behavior, to remove him from an impossible position. The treatment, which is remarkably effective, is to uncover it and to allow it full expression with reassurance and re-education about the normalcy of fear in dangerous situations.

One of the most important functions of military training is to reverse the training already given to our young men in their homes and their communities. Officers and N.C.O's must repair the deficiencies left by parents. It is necessary extensively to reorient their attitudes about their relationship to the group. Most of their previous education has been preoccupied with the responsibility of the State to the individual and with the rights of the individual. To make good soldiers requires extensive re-education. It is important that these necessary new attitudes should not just be overlaid or superimposed on their home training but that the attitudes in which they were brought up should be broken down, and replaced, not just ignored. It is also important that all soldiers in training and throughout training should be introduced to fear and its manifestations and should learn to live with fear as they will have to do throughout the war. It is reasonable to suppose that if 80 or 90% of anxiety states can be got back to selected duty by early treatment close to the front line they can be just as effectively prevented from breaking down by the same type of treatment as a preventive measure.

Fear should be brought out into the open and experienced fully. All troops should learn that the experiencing of fear need never cause a soldier to panic or to avoid a responsibility. Fear must be made respectable and recognized as a benign protective mechanism which prepares the organism for supreme effort.

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MALINGERING; THE SIMULATION OF PSYCHOSIS

BY V. P. OSSIPOV, M.D.*

Malingering belongs properly to the domain of psychiatry, but has been variously regarded. In olden times it was thought that simulation of a psychosis was a simple matter. But Kraepelin and others denied this. The impression has grown that "pure malingering" rarely exists as such; every malingerer is really an unstable person, a psychopath, who by imitating a psychosis merely accentuates his own latent tendencies so that malingering is really pseudo-malingering.

At the present time there is quite an accumulation of literature on this subject. Contradictory opinions exist partly because of different personal experiences and partly because psychiatry itself has undergone changes in its development. I personally believe that the simulation of psychosis for malingering is very uncommon. Malingering in its pure form appears usually in times of great social upheaval when punishments for crimes are very severe or when the situation is such that one's life is threatened. In such periods large numbers of people develop defense reactions by means of which they hope to escape punishment or death. Thus, there were quite a few cases of malingering in the U.S.S.R. during the civil war when banditry was being eliminated and the captured bandits were condemned to death. But in the last few years this type of crime has decreased, although different kinds of criminals such as speculators, embezzlers and swindlers occasionally resort to this type of self-defense.

In the days before the revolution there was malingering to avoid military service; at the present time one hardly ever finds this. On the contrary, the inductees try to conceal their illnesses so that they will not be rejected by the induction boards. This is most common in epilepsy. Many epileptics are sent back to psychiatric hospitals after they have been in the Red Army for a long time.

In this article I shall discuss the most important methods of discovering malingering and the evaluation of the various symptoms. One must take into consideration the fact that psychiatry has developed a great deal in the past 10 or 15 years and for this reason the various forms of malingering

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are more complex and harder to detect, and hence the examining psychiatrist must be a very competent person. Of course one encounters the older, cruder ways of malingering but they are well known and easily recognized.

Every malingerer is an actor who portrays an illness as he understands it; in this case he plays the role of a psychotic patient *as he understands it.* Consequently, he imitates those traits of a psychotic which he thinks are especially characteristic such as sloppiness, bizarre behavior, unmotivated excitement alternating with periods of rest, etc. This accounts for the contradictions in symptomatology and the fact that the picture of mental confusion does not correspond to the medically recognized clinical picture of this state. Thus the malingerer who tries to mimic an emotional excitement with incoherent speech, at the same time listens attentively to people around him and makes perfectly rational remarks to the psychiatrist. He invariably wears his shirt and coat inside out. When he simulates a stupor, he carefully watches the people around him at the same time and listens closely to the remarks of the members of the staff to the effect that he does not show certain symptoms. Quite frequently the malingerer is revealed by the play of facial muscles and by the lability of his vegetative nervous system in response to various emotional stimuli. This is evidenced by marked variations in the pulse rate, blushing, ready crying, flushing, etc. He is readily betrayed by the marked change in his behavior in the presence of the medical staff and absence of any reaction when he is alone at night or when he feels no one is watching him. One must watch carefully the facial expressions and the gestures of such a patient. He is often betrayed by his vigilant watching or sudden laughter when he is supposed to be feeling quite the other way. Thus one criminal who for more than a year was in a state of stupor suddenly burst out laughing when his attorney made a comical remark about him during the trial. Then and there he stated that he was tired of acting and confessed his crime. This was reinforced by the sudden appearance on the witness stand of a young woman whom he thought he had murdered.

A carefully conducted interview often reveals malingering, especially if the malingerer is caught contradicting himself. Occasionally such malingerers, in trying to give the impression that they are in a stupor, refuse to take food from one person but take it from another, or from time to time become gluttons or eat at night when nobody can see them. One must watch the weight curve, which is significant in certain psychoses. Frequently persons who commit crimes while in a state of intoxication insist that they remember nothing—amnesia, of course, is a definite symptom of a pathological state of consciousness but only if it is correlated with other

symptoms which go with this or that clinical picture. In real amnesia one usually finds fragmentary cloudy memories. Malingerers insist that they remember nothing. If they admit that they remember one part of the amnesia they usually remember the rest of the story. It is interesting that the malingerer forgets that particular phase of the episode which is most harmful to him. Occasionally such an amnesia can be uncovered by the association tests of Jung.

In imitating the behavior of a psychotic patient, the malingerer goes to extremes. If he is told to shut his eyes, he does not close his lids, but uses his fingers to bring the lids together. When someone shakes hands with him he uses his left hand instead of his right. Another malingerer when going to sleep, puts on his glasses and lights his pipe. Such conduct is due to the fact that the malingerer thinks that the stranger he behaves, the more psychotic he will be assumed to be. When given difficult questions he shows no response; when asked simple questions, he takes a long time to answer. Occasionally talking beside the point is found. Rapid firing of questions occasionally throws the malingerer into a state of confusion so that he begins to give contradictory replies which help to elucidate his condition. Sometimes it is desirable to ask leading questions emphasizing a different psychosis than the one the malingerer tries to portray. The confirmation and elaboration may give good clues. Of great importance is the past history of the patient. Malingering of a psychosis usually stops when it is discovered and occasionally even if the malingerer wins his case. It may cease, too, when the malingerer becomes too tired to pursue it or discovers its uselessness or when he attains his aim. Malingering usually stops quite suddenly. The continuation of the clinical picture of a psychosis even when it has lost its meaning speaks for a genuine psychosis rather than malingering.

One must give careful attention to the onset of the malingering. Mental illnesses, even those which are very acute, usually have a very slow onset. They usually develop in a course of hours or days whereas a simulated psychosis is apt to set in very suddenly without any preliminary signs. Thus a criminal suddenly develops a psychosis when he is in danger of losing his case by a careless remark, or is confused, or when he feels caught. In such cases the malingerer suddenly becomes mute, refuses to answer questions, or begins to talk all sorts of nonsense and to act silly. Very often the criminal shows symptoms of various psychotic illnesses but not in the combination in which one finds them in psychoses.

In spite of all these points, it is often impossible to differentiate between a psychosis and malingering on the basis of symptoms alone. One must take into consideration all the factors. In general it is very difficult to

diagnose these cases when one does not have a good history. (Here the author cites two cases, omitted for reasons of space restriction, which illustrate the points made above).

CONCLUSIONS

1. In medico-legal practice, as well as in military courts, one occasionally finds true malingering by simulation of a psychosis.

2. At the present time there is a tendency to conceal one's physical and mental illnesses when entering the Army rather than the reverse. This especially is true of epileptics.

3. With the development of psychiatry and the greater knowledge of it by the laity, malingering becomes more skillfully performed and requires a great deal of competence and perspicacity on the part of the psychiatrist.

4. Medico-legal experts should be well acquainted with the various methods used by malingerers. To elucidate malingering one must have keen powers of observation and imagination.

5. A good objective history is of great importance.

6. The behavior of the malingerer after the case is settled is of significance.

7. It is important to know the setting in which the malingering begins as well as the time of the onset and the nature of the malingering.

8. If one finds mental symptoms in a soldier it is best not to make a clinical diagnosis immediately but to limit oneself to the term "psychosis." In a field hospital a diagnosis is very hard to make; there is also the danger that if a definite diagnosis is made there will be a certain fixed prejudicial attitude on the part of the hospital personnel because of the specific diagnosis assigned. This applies especially to the diagnosis of schizophrenia.

9. A great deal of attention has to be paid to the course and development of a mental illness suspected of being a simulated one. Malingerers tend to portray a "state" or an episode, but not a disease. One must evaluate the whole clinical picture rather than the individual symptoms.

10. One must take into consideration the lability of the vegetative nervous system.

11. In military psychiatry, one must think more of the fitness of the man for military service than of his degree of insight and awareness.

12. The expert must be very objective and strive to avoid subjective bias in dealing with malingerers.

13. Conclusions must be based on concrete material. One should record the facts observed rather than resort to psychiatric terminology. Only then are the conclusions significant in deferentiating between a genuine and feigned psychosis.

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TEACHING OUTLINES OF PSYCHIATRY FOR NURSES AND ATTENDANTS

By COLONEL WILLIAM C. MENNINGER, M.C.

It is universally recognized that all personnel working with psychiatric patients need specialized training in psychiatry. Even with a high intellectual endowment, a nurse or attendant with no such training may do little good and much harm. In our Army hospitals, where there is an acute shortage of psychiatrists, it is all the more important that the nurses and attendants not only be trained in their duties as assistants to the psychiatrist, but instructed in the ABC's of psychiatry in order to be taught the rationale of their functions. The facts that the ward personnel changes often or that certain assigned attendants may have limited intellectual capacity are all the more indication for the necessity of conducting training.

Because the medical officers in many hospitals were too busy to organize some lectures for these attendants and because others felt a lack of teaching experience, the following outlines were prepared. The subject matter is organized under seven headings divided according to content, but since the sections are of different length, they need not necessarily be presented in seven sessions. The presentations should be made by the psychiatrist to his nurses, corpsmen, therapists, and Red Cross workers. They should be modified by the instructor with additions and/or deletions to meet the local needs. It is advisable to use case illustrations wherever possible and to allow periods for questions and discussions. Outside reading of available texts and journals should be encouraged and guided.

LECTURE I: ORIENTATION TO PSYCHIATRY

I. *Define psychiatry* as the study, diagnosis and treatment of illnesses in which the psychological symptoms (and their conversion into physical complaints) predominate.
   A. Practice in this field includes
      1. The care of patients in state and government hospitals: more than 50% of all hospital beds in the United States are for mental patients
      2. Private practice of psychiatry in hospitals, clinics, private offices
      3. Applications in medicine—psychosomatic medicine
      4. Application in legal work—courts, reformatories, prisons, etc.
      5. Application in schools—kindergarten, primary, secondary, colleges
      6. Application of psychiatry in industrial concerns
      7. Applications in community welfare and social agencies

B. Difficulties in presenting psychiatry to laymen arise because
   1. Each person thinks he is an exception and wishes to regard himself as "normal"
   2. There are many misconceptions about mental illness being related to sinfulness, queerness, meanness, disgracefulness, etc.
   3. The field is intangible and cannot be objectified so easily as laboratory science
   4. Many individuals assume they instinctively understand human and psychology behavior

II. *The Psychiatric Point of View*
   A. The individual is conceived of as a total personality (emotions, skin, muscle, viscera) reacting to a total environment (bacteria, alcohol, automobile accidents, bullets, nagging, mothers-in-law, frustrating lovers). Result is fight, flight, or compromise.
   B. The old concept of mind and body as entirely separate entities is an unsound, mythical division
   C. A reorientation to the term "normal"
      1. "Normal" is often used to mean average or majority ideal
      2. But in psychiatry it means adjustment to the environment without inner or outer strain. Hence it is always relative and not an absolute concept; for
      3. Everyone has adjustment conflicts, neurotic tendencies, minor or major unhappiness, eccentricities, mood fluctuations
      4. Quantitative factors are more important in determining pathology than qualitative.
      5. Mechanisms operative in severely ill individuals are also operative in less degree in well individuals, so that we are all at times "low," "mad," "unhappy," "excited," "jealous," "nervous," "fearful," etc.
   D. A reorientation to the term "sickness"
      1. In general medicine 40% to 70% of all patients seen by any physician are "functional" and all organic illnesses show psychologic symptoms: delirium, anxiety, pain, restlessness, etc.

III. *Prevalent misconceptions regarding mental illness*
   1. That all psychiatric patients are "crazy"—usually noisy and destructive
   2. That all mental disease has the same cause and is usually related to "sin" or "perversity" (conscious intent)
   3. All mental diseases are alike, differing only in degrees
   4. That heredity is the chief cause of mental disease
   5. That people are either "sane" or "insane"

6. That most mental patients are dangerous to themselves and/or to others
7. That mental illness starts suddenly when "something snaps" in one's mind
8. That a "nervous breakdown" is a disease of the nerves
9. That mental illness is a disgrace
10. That most mental disease is incurable

LECTURE II: SYMPTOMS AND TYPES OF SEVERE MENTAL ILLNESS

I. Major Groups of Mental Illness and Symptoms: Definitions

A. *Psychotic reactions* (psychoses) characterized by disorganization of the personality, usually with loss of insight (recognition of the severity or/and significance of their symptoms) and always with various forms of reality distortion as shown by

1. *Delusions:* fixed false ideas not amenable to reason (paranoid, expansive, somatic and other types)
2. *Hallucinations:* false perceptions without external stimuli (visual, auditory and other types)
3. *Illusions:* misinterpreted perceptions of sensory stimuli

B. *Neurotic reactions* (psychoneuroses or neuroses; popular terms include "nervousness," "nervous breakdown," "nervous exhaustion," etc.) characterized by wide variety of symptoms but without gross distortion of external reality (delusions, hallucinations, illusions). Symptoms represent compromise reactions such as

1. *Conversion:* physical representation of an emotional process, i.e., paralysis, aphonia, anesthesia (illustrate blushing as a physical expression of an emotion and elaborate then with various organ neuroses)
2. *Obsession:* persistent recurrence of an idea against volitional control (illustrate first with "normal" obsessions—tunes going through one's mind, then with such recurring doubts as "did I lock the door?", then with pathological obsessions, e.g. syphilophobia, etc.)
3. *Compulsion:* The activity associated with or representative of an obsession (illustrate first the normal compulsions of orderliness, punctuality, cleanliness, and show how any of these may increase to pathological dimensions)
4. *Phobia:* fear not amenable to reason or in keeping with the facts (illustrate with fear of snakes, cancer, closed spaces, etc.)

C. *Developmental defect reactions:* antisocial or/and unconventional behavior with absence of appropriate emotional reactions.

(Emphasize the lack of sharp demarcation, the frequent overlapping, and the exclusion of the psychopathology of everyday life as demonstrated in the maladjustments of everyday life of ourselves.)

II. *Condensed classification of mental illness*

A. *Psychotic reaction*

1. *Organic types:* those which arise upon a demonstrable organic or toxic basis
   - *a.* Psychoses with brain infection and paralysis, encephalitis
   - *b.* Psychoses with senile or arteriosclerotic changes
   - *c.* Psychoses with exogenous poisons (alcohol, drugs, metal)
   - *d.* Psychoses with endogenous poisons (generalized infections, cardiorenal disease, exhaustion)
   - *e.* Psychoses with systemic disease (pellagra, pernicious anemia, endocrine disorders)
   - *f.* Psychoses with brain damage from tumor or trauma
2. *Functional Psychoses*—no demonstrable anatomic or chemical pathology; include 50% or 60% of all psychotic responses
   - *a.* Manic-depressive psychoses (briefly describe a clinical picture of at least the manic, the depressive, the agitated and mixed forms)
   - *b.* Schizophrenia (dementia praecox) (briefly describe the simple, hebephrenic, catatonic and paranoid types)
   - *c.* Paranoia and paranoid states. (illustrate)

B. *Neurotic reactions*

1. *Neurasthenia and hypochondriasis:* many physical complaints —for which the patient tries to demonstrate an organic pathology but the physician finds none
2. *Conversion hysteria:* physical representations of emotional conflict
3. *Anxiety state:* characterized by obvious, free-floating anxiety
4. *Obsessional and compulsive neuroses* (sometimes referred to as psychasthenia): the patient is unable to change his ideas or behavior even though recognizing them as irrational and painful
5. *Mixed types.*

C. *Developmental Defect Reactions*

1. *Perversions:* overt sexual perversions develop without conflict and represent an acceptable (ego) solution for the individual—but are nonetheless pathological. (Explain again that neuroses develop because of unconscious mental conflict and

the symptoms of the neuroses represent a compromise reaction.)

2. *Neurotic and Psychotic Characters*—often designated as *constitutional psychopathic state.* These individuals act out their maladjustment conflicts in asocial and antisocial behavior *instead* of developing symptoms. Characterized by inadequate social values and responsibility, inability to profit by experience, disloyalties in their relationships, etc.
3. *Criminality:* describe the "normal" type, the neurotic type, the situational type
4. *Infantile or Parasitic Personality:* inadequate, passive, dependent, helpless individual, often classified in the Army as *constitutional psychopathic state*
5. *Feeblemindedness:* intelligence and judgment quantitatively defective. Often organic but sometimes emotional causes may cause some mental retardation
   a. Causes—primary (heredity); secondary (birth injury or disease)
   b. Classes—mongolian, cretin, sclerotic, spastics, micro and hydrocephalic, etc.
   c. Grades—Moron, I.Q., 50–70. Imbecile, I.Q., 30–50. Idiot, I.Q. below 30

LECTURE III: CONTRIBUTING FACTORS IN CAUSATION OF MENTAL ILLNESS

I. Specific "cause" of an illness (i.e., pneumococcus in pneumonia) is convenient practical explanation, but inadequate: does not consider factors of personality, degrees of virulence, immunity, carriers, physical conditions, etc. In mental illness, the instructor should emphasize
   A. Never one cause for mental break—many factors operative in every case, some more important in one instance than in others
   B. Response of certain equipment (the total personality) to those events
   C. The train or sequence of events

II. *Hereditary Factors*

Accepted facts *re* heredity

A. Mental disease is not inherited according to Mendelian Laws (like eye color, etc.)
B. A few neurological conditions are directly transmitted: (Sydenham's Chorea)
C. Probably some tendency to mental disease is transmitted in some instances but quantitative evaluation not possible

D. Often it is impossible to separate and distinguish the inherited environment from the inherited constitutional potentialities. Summary: A hereditary factor is probably present in some cases; its importance is very difficult if not impossible to evaluate; its diagnostic and prognostic significance is minimal; it has no bearing on treatment.

III. *Environmental Factors*

A. Infantile experiences and relationships are of major importance in determining later personality adjustments

1. Early feeding and toilet training determine patterns of reaction to authority, dependence, acquisition, etc.
2. Early patterns of relationships formed with parents and siblings determine patterns of later social adjustments
3. Important (often traumatic) events in childhood and adolescence.

Summary: A factor of greatest importance in understanding the patient's attitudes and behavior, valuable as diagnostic and prognostic aid, and of first importance in planning and carrying out treatment.

IV. *Precipitating Factors:* may often appear to be the immediate or exciting "cause"—really they are only the final (though necessary) "straw"; the final event in sequence on a fertile soil; the curtain going up on a stage set and a play rehearsed. (Applies also in organic illness: the personality plus the disease produces the clinical picture. Illustrate with general paralysis: same pathology with widely varying clinical pictures.)

A. Emotional deprivations (real losses)

1. Economic loss or reverse
2. Deaths of significant persons

B. Insecurity and Threatened Deprivations

1. New situations—job, school, Army, marriage
2. New responsibilities
3. Situations which are threatening—danger, fear

C. Physical and physiological burdens

1. Physical stress—work, exhaustion
2. Injuries
3. Systemic or infectious disease
4. Focal infection

LECTURE IV: MENTAL MACHINERY

I. Conscious and Unconscious—to gain an understanding of human behavior we must postulate these functional parts of the personality:

A. *The Conscious Mind* endeavors to:
   1. Control voluntary activity, both psychic and muscular
   2. Coherently organize mental processes
   3. Test reality—to orient us, to distinguish true from false, etc.

B. The Unconscious Mind of powerful impulses, manifests its contents directly in
   1. Dreams—the "excreta" of the psyche
   2. Phantasies
   3. Personality changes noted in many people under influence of alcohol—Jekyll-Hyde changes
   4. Psychopathological symptoms, e.g. delusions
   5. Hypnosis and free associations

II. *Mental mechanisms* link the conscious and unconscious; facilitate energy transfers between the two. These mechanisms are all unconscious, and not consciously willed by the individual. Examples—

A. *Rationalization:* a method of explaining plausibly and thus accounting for and justifying certain feelings, ideas, or behavior, the explanation appearing to be the result of logical thinking. Examples: procrastination explained as caution, etc.

B. *Displacements:* the emotional value attached to one idea or person is transferred to another idea or person. Examples: kicking the dog.

C. *Sublimation:* primitive desires and impulses obtain an outlet in modified form through direction of the original energy into socially approved activities. Examples: hobbies (collections, painting, etc.)

D. *Reaction Formation:* the development of conscious attitudes and interests which are the antithesis of infantile trends demanding expression. The person does or says the opposite of his unconscious wish. Examples: excessive solicitude to repress hostility; phobias of symbolic objects desired, i.e., dirt or syphilis; excessive cleanliness.

E. *Conversion:* the symbolic expression by means of physical symptoms of both unrecognized (repressed) instinctual wishes and the defense set up against their realization. Examples: anesthesias, aphonia, paralysis; and less obvious ones like headache, low back pain, dysmenorrhea.

F. *Projection:* a method whereby in order to protect one's sense of security, he transfers to another person or object his own (hostile) wishes or inadequacies. Examples: blaming others for one's mistakes; paranoid delusions.

G. Other mechanisms to be mentioned and discussed if time per-

mits: introjection, repression, undoing, condensation, symbolization, compensation.

LECTURE V: PSYCHIATRIC EXAMINATION

Every psychiatric patient should have a psychiatric examination. This is made by the doctor but the attendant can help, if he knows what the doctor is doing. For this reason attendants should be familiar with the parts of a mental examination outlined below.

I. *Precede* mental examination with
   - A. History (preferably from sources other than patient): Present illness; developmental and social history; medical history, family history
   - B. Physical examination including indicated laboratory and X-ray studies
   - C. Neurological examination and any special procedures such as lumbar puncture, air encephalogram, electroencephalogram

II. *Mental Examination:* combination of observation and interrogation, ideally made over a period of a week or more—a cross-section descriptive picture of the personality. Details:
   - A. *General Observation:*
     1. Patient's dress, mannerisms, facial expression, gait and posture.
     2. Attitude toward examiner and examination.
   - B. *Perception:*
     1. Alertness and orientation as to time, person, place.
     2. Recent memory: since this is based primarily on perception, ask *re* present situation, present associates, how he came here, etc.
     3. Presence and degree of confusion or disorientation.
     4. Are hallucinations or illusions present?
   - C. *Intellection:*
     1. General mental content—the patient's story from which many other points in the mental examination are derived.
     2. Insight: degree of recognition of the total situation and his problem in particular.
     3. *Delusions:* paranoid, expansive or grandiose, nihilistic and other types.
     4. Judgment as judged by his attitudes, behavior, etc.
     5. Knowledge—general grasp of information, facts, persons, events, etc.
     6. Intelligence: the ability to utilize or apply knowledge. Special tests necessary for accurate determination. Roughly judged by calculation tests, practical problems, etc.

7. Are obsessions present?
8. Type of phantasies and dreams
9. Intactness, remote memory

D. *Emotion:*
1. Type and degree (intensity): depressed, excited, dull, agitated, euphoria, etc.
2. Range, and lability, fluctuations, variations.
3. Interpersonal relationships with doctors, nurses, attendants, other patients.
4. Object interest: work, reading, games, etc.

E. *Action:* (behavior)
1. Types, degree, range, impulsiveness.
2. Participation in occupational therapy, recreational therapy, ward work, etc. (and, previously, in assigned details)
3. Sleeping habits.
4. Eating and smoking habits.
5. Excretory habits.
6. Sexual habits.

F. Summarize the chief psychopathological features manifested.

LECTURE VI: MANAGEMENT OF PSYCHIATRIC PATIENTS

I. *Personality qualifications* which an efficient psychiatric nurse or attendant should cultivate
A. *Alert watchfulness:* "Eternal Vigilance" for danger signals, suicide threats, combativeness, escape tendencies, etc.
B. *Sharp observation ability*—Observations of even minor changes in mood or behavior of patients are often of great value to physician.
C. *Efficiency:* degree of compulsiveness and industry determines the effectiveness of treatment, morale of patients, appearance of ward.
D. *Tact:* patients often must be refused requests, restricted in activities, confined, etc. The method by which these are done and explained to the patient may make the patient better or worse.
E. *Native intelligence and good judgment:* "Experience is best teacher" but only if new nurse or therapist knows that he has much to learn.

II. *Attitudes to be assumed towards patients*
A. "Attitude Therapy"—confidence on the part of a patient in certain persons (doctor, nurse, attendant) and the kindness and consideration shown by them are most important elements in successful treatment. This requires

1. *Absolute truthfulness,* always.
2. *Controlled emotional responses*—do *not* show anger, irritation, annoyance, fear, excitement. (Give examples.)
3. *Active friendliness:* patient often cannot take initiative to be friendly, may not even want to do so. Consequently the nurse must take the initiative in building the rapport.
4. *Tolerance:* nurse must be tolerant (though manage situation) when patient is abusive, vulgar, aggressive, noisy. Often part of patient's intention may be to disturb environment.
5. *Avoid condescending attitude:* our patients are adults (at least chronologically) and in so far as possible treat them as such.
6. *Do not argue with patients:* Say what you mean and then show that you mean what you say. Do not try to argue a patient out of a delusion.
7. *Use praise and commendation* wherever and as often as it is justified. We all crave approval, and this is especially true of the psychiatric patient.

III. *Special Emergency Problems*

A. *Suicide*—occurs too often
   1. Take precaution: remove sharp instruments, bath robe belts, glass, etc., shaving, eating, etc.
   2. Observe changes in patient's behavior. (Suicide often occurs as patient begins to improve!)
   3. Remember importance of constant vigilance.

B. *Combativeness:*
   1. Attitude of calm friendliness and firmness particularly of nurse alone often effective.
   2. Never strike or injure patient.
   3. Use enough man power to overcome patient without hurting him.
   4. Protect yourself with pillow, blanket, etc.
   5. Follow physician's orders regarding isolation, restraint, pack, sedation.

C. *Feeding Problems:* expert psychiatric nurse often can get a patient to eat who otherwise will not. Importance in the approach, method, etc.

D. *Escape:* often can be suspected by actions, and prevented before accomplished.

E. *Physical health problems:* fever, dehydration, constipation, urinary retention, etc., all responsibility of nurse to report.

IV. *Reporting and Charting*

A. *Special Importance* in psychiatric nursing because

1. Physician may see patient only a few minutes a day; nurse and attendant see him for hours.
2. Patient often presents more typical picture of himself to nurse or attendant than to physician.

B. *Values in charting*

1. Can be of great aid to physician in determining diagnosis and guiding treatment.
2. Legal value to hospital in case of difficulties.
3. Good charting improves standard of care and treatment.

C. *Methods of charting*

1. Frequency is an administrative decision.
2. The ABC's of charting are: report the appearance, behavior, and conversation, i.e., what you see and hear, not what you interpret it to mean.
3. Avoid routine and stereotyped remarks; use verbatim comments.
4. Oral reports may be necessary in emergencies.

LECTURE VII: TREATMENT METHODS

I. *The Primary aim of all medicine is treatment*

A. *Variations in application in psychiatry*

1. Patients are usually ambulatory and thus physically able to be active.
2. Medication and surgery are only for symptomatic help and relatively unimportant.
3. The patient may or may not appreciate his need for help; often not cooperative.

II. *Forms of treatment*

A. *Individualized measures:* instituted and directed by physician

1. *Psychotherapy*—suppressive and expressive types. Nurse and attendant may aid patient through suggestion and/or persuasion under doctor's direction.
2. *Physiotherapy*

a. Hydrotherapy: explain indications, method, and expected results with prolonged emersion tub, wet-sheet pack.

b. Massage: indications and methods.

c. Stress psychological value of personal contact procedures.

3. *Medication*
   a. Vitamins: types of deficiencies.
   b. Sedatives: indications, doses, toxic effects of common sedatives.
   c. Special drugs: benzedrine, anti-syphilitic drugs, endocrine preparations, etc.
   d. Symptomatic medication: tonics, iron, etc.
4. *Shock treatment*—explain insulin, metrazol, electroshock. Discuss indications; methods; results.

B. *General environmental (milieu) measures*—(Stress the point that the nurses and attendants have *major* responsibility for these.)
1. *Living conditions:* attractiveness and cleanliness of ward; "comfortableness" and "friendly atmosphere."
2. *Occupation:*
   a. Advantages of keeping patient busy.
   b. Assisting with ward work.
   c. Special activities in craft work, painting, collecting, constructing, designing, model making, gardening, etc.
3. *Recreation* (often help available from Red Cross Service)
   a. Some patients do better in group play; others in two-person games (checkers); still others in solitary games, (punching bag).
   b. Similarly, a variety of recreations should be provided; indoors, outdoors, competitive, non-competitive.
   c. Reading, music and other cultural fields can and should be used—they are frequently very beneficial (consult Red Cross).

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PSYCHODYNAMICS OF AUTHORITY WITH RELATION TO SOME PSYCHIATRIC PROBLEMS IN OFFICERS*

BY CAPTAIN NORMAN REIDER, M.C.

In making observations on psychiatric casualties among officers in the Army, one is struck with the fact that attitudes toward authority often figure prominently in their psychological problems. This is to be expected since we know that one of the oldest conflicts in human beings, dating back to early childhood, is the conflict between the wish to be omnipotent and self-assertive and the need to secure food, protection and love through obedience to the parents. The widely varying compromises by which each person resolves this fundamental conflict determine to a large extent his life-long attitudes toward all external authority.

Furthermore, in a democracy it is difficult to transform quickly a people who lack any great militaristic tradition into a militarized and well-disciplined organization. The tradition of individualism in which our people were reared conflicts sharply with the requirements of military discipline and obedience resulting in the reactivation of the unconscious conflicts of childhood. Hence, in the armed forces we see various unsuccessful solutions to the problem of dealing with authority: over-submissiveness, willful disobedience, A.W.O.L. episodes, and breakdowns into illness.

Favorable aspects of the adult representation of childhood reactions to authority can also be seen in military life. The affection and respect that a well disciplined soldier has for his superior officers, the pride he takes in his organization, his readiness to submit to authority are, to be sure, immediate results of proper basic training and indoctrination. But these training factors serve to mold and polish an already responsive, plastic material. As evidence for this it can be stated that when there is pride in an organization, respect for superior officers, over and over again one can see as an integral part of this pride the identification of the enlisted man with his superior officers and a participation with them in their authority through submission to them. From such enlisted men one hears the expression "My outfit is the best one," and there is no hesitation in speaking to their superior officers about "our organization." In contrast to this, in the neurotics and psychopaths it is a striking fact that there is little identification with their organization or their superior officers. They never speak of "my outfit." They remain emotionally isolated from and at odds with their group. Very frequently such individuals give the history of a broken home, divorce, or desertion. These are the individuals who made no

*Presented at a Staff Meeting of Hoff General Hospital, Santa Barbara, Calif., March 15, 1943.

healthy identifications in their childhood and they show the same lack in the Army.

Theoretically, there should be no difference between such problems in enlisted men and in officers, and I really believe that there is no fundamental difference. Nevertheless, clinically we see some shades of difference which I wish to discuss now. There is not time to cite case material, but I have noticed several specific kinds of problems among officers. How many other kinds of problems there are I do not know, but there are probably many. I am not considering those who were maladjusted or patently neurotic in civilian life, who would have difficulty in adjusting to military life, regardless of circumstances.

One problem which interests me is that some men who were apparently quite successful in civilian life become such abject failures in the Army. How does one account for such differences in performance? In the main two different kinds of emotional instability underlie the problems of officers of this sort. First, there are those who were pre-eminently successful in civilian life, just because the drive that motivated them was an exaggerated protest against early authority. Disillusioned or dissatisfied by what was given them in return for their submission to external authorities, they overcompensated in civilian life by bursts of independence and defiance, and assumed authority themselves. Because their independence was not a mature achievement but rather a form of rebellion, they feared that someone would surpass them and were constantly driven by anxiety to accomplish more and more in order to maintain their supremacy. It is possible for such an individual to be a similar success in the military only if he is in complete authority himself. No matter how much responsibility he has to the men under his command, he will tend to turn all his emotional energy toward the struggle with his superior officers and to re-enact against them the unsolved conflicts and rivalries of his childhood. Incompletely resolved anxieties and forces of rebellion which had been kept beneath the surface as long as he was able to outstrip his rivals in civilian life will break through in the Army.

A second type of civilian success which turns to failure in the Army is a type much more common than the first. It occurs in the individual whose success in civilian life was more apparent than real. These are the individuals who were essentially dependent upon others for their success, whose apparent achievement was only for the purpose of satisfying a socially imposed necessity before they could get their wishes gratified by others. These are the men who often have very maternal wives or who were associated in a profession or business with abler and perhaps older men. Sometimes it is quite obvious that these individuals are essentially dependent characters but often it is not evident, at least to the untrained observer.

The fate of such individuals, so far as I have been able to see, varies with the circumstances which they encounter in military life. Should such an officer be placed in a situation analogous to that in his civilian life, one in which he has the kindly guidance of a superior officer who is affectionate and quick to give praise, or should he be stationed in a place where his wife can be with him, he may continue to get along well. Should he be so assigned, however, that his great need for affection and support is not forthcoming from a figure of authority, he will collapse in one of the very well known ways of falling into illness, such as by developing depression or anxiety. This mechanism should be stressed because it is fundamental in connection with the problem of reclassification and reassignment of officers. If an officer who shows signs of maladjustment can be studied as to the emotional basis for his failure of adaptation, recommendations for reassignment can often be made which have a good chance of resulting in a successful readaptation.

There is a third psychological problem which I have noted, which is also more common than the first, but fortunately does not give so much trouble. It is quite possible for some individuals who are not well adjusted to authority to get along well in the armed forces if they have time to orient themselves. The reason why such persons require a longer period of time to make the adjustments to authority required in the Army is that their adjustment to external authority in civilian life was characterized by a peculiar rigidity. They were free from anxiety, not because they had solved their childhood fears and impulses to rebel, but because they had learned to control them by means of unconscious repression and conscious inhibition. Such persons devote such a large proportion of their energy to controlling themselves by various conscientious devices that they have a limited ability to adapt themselves to new experiences. Any change in their external situation or routine, often regardless of whether or not it affects their lives adversely, arouses anxiety. Such individuals are apt to have attacks of anxiety and depression when they enter military life because they feel themselves to be no longer in control of the situation. To some this is a major problem. To others, it is simply a minor difficulty which they can get over if they have sufficient time in which to master the new situation.

There is still one other syndrome which I have seen a sufficient number of times to be able to describe. This occurs in individuals not upon their entering the service or after having been in the service a short time, but much later when they are promoted, after having made an apparently good adjustment in military life. When emotional difficulties develop under such circumstances they are usually ascribed to the pressure of increased responsibility which is too much for the individual to bear. But I doubt

that the responsibility itself is as important as what that responsibility means to that individual. In the few instances in which I have had the opportunity to go beneath the surface, where promotion was the definite precipitating factor, I found that these individuals are closely allied to the second group mentioned above; i.e., they are essentially dependent individuals with feelings of inferiority and fear of failure, who can adjust themselves only at a certain level. The thing that distinguishes this smaller group is that these are the individuals who cannot stand success very well, and for whom the promotion means "now you are equal to your superiors; be like them." This state of equality with figures of authority is what is psychologically intolerable to them. Submission is a necessary condition for them to be in if they are to get along well. As soon as this condition is removed by promotion, they are overwhelmed by anxiety and sometimes by depression.

One last word about the problem of medical officers. They constitute a relatively high percentage of all officer patients. To say that doctors are more neurotic than other groups of officers may be true, but I do not think this is sufficient explanation. I think that in doctors another factor operates which is an exaggeration of factors already mentioned. The doctor in civilian practice, whether he is aware of it or not, gets a great deal of narcissistic satisfaction out of his profession, probably much more than do the members of any other profession except the ministry. He is "closer to God" than other men in the sense that he is dealing with life and death. He exerts in his way a unique type of authority. Many doctors whose personal lives are very unhappy, who get very little satisfaction or fun out of life, get a great deal of satisfaction from their profession, because it fulfills their need to be omnipotent, a need which all of us experience in childhood because of our weakness and helplessness. The persistence of this childhood wish to be all-powerful is often an unconscious factor in the choice of medicine as a profession. When physicians to whom this unconscious satisfaction is very important enter the military service, the illusion of omnipotence which had more or less sustained them in private practice, vanishes abruptly and the emotional needs which were satisfied in civilian practice are now frustrated.

The facility of making favorable identifications as the prime prerequisite for good morale is just as true for officers as it is for enlisted men. The differences have to do with age, plasticity, and the ability of the army to meet the respective needs.

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FUNCTIONAL MUSCULAR DISABILITIES: THEIR RECOGNITION AND TREATMENT

BY CAPTAIN EARL SAXE, M.C.*

Functional muscular disability comprises over 50% of cases admitted to this hospital as organic neurologic disease. The most common entities for which this psychogenic manifestation is mistaken are spinal cord tumor, herniated intervertebral disc, peripheral neuritis, encephalitis, brain tumor, and degenerative diseases such as multiple sclerosis and syringomyelia. It is the purpose of this article to discuss psychogenic muscular disorders as seen at this installation, to touch on several methods of differentiation from muscular disorders of organic origin, and to indicate the appropriate therapy.

Because of the underlying psychopathology in these cases, a mistaken organic diagnosis is of serious portent. It represents an authoritative affirmation to the patient of a non-existent condition upon which the whole framework of his illness is consciously founded. The psychopathology becomes more deeply embedded and the entire superstructure of somatic symptomatology increases in stability. This is especially true where conversion symptoms are engrafted on real but minimal structural change. Invalidism is prolonged, therapy is more difficult and often unsuccessful.

The importance of early diagnosis is therefore quite evident. It cannot be stressed too strongly that this alone is the greatest single adjunct to successful specific therapy. Diagnostic methodology which has led to certain recognition of these cases in their variety of manifestation falls into four divisions: History, Muscle Analysis, Electrical Testing (of muscles), and Barbiturate Narcosis.

Careful history often reveals previous attacks of conversion hysteria such as temporary amblyopia or aphonia. If not diagnostic in itself, such a story introduces the strong possibility of the psychogenicity of presenting symptoms. Close questioning will also reveal in many cases the psycho-traumatic content of events precipitating the presenting symptoms.

It must be emphasized that the neurotic manifests the loss of a particular *function* rather than the ability to utilize a particular group of muscles. His form of somatization is based on the experiential, not the physiologic. Careful muscle analysis will reveal the structural and physiologic continuity of muscles and muscle-groups. Several examples will adequately illustrate the importance of this procedure. Patient X was unable to extend the flexed leg; he suffered an apparent loss of function of the quadriceps. However, when flat on his back, his legs extended, he was able to

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abduct both legs against resistance. The patient's psyche did not know the quadriceps was not only an extensor but also a leg abductor. The same confusion of physiology often exists in the dual function of the biceps brachii of flexion of forearm and supination of the hand.

Testing the same group of muscles with the patient in various positions is also a useful maneuver. Patient Y gave evidence of biceps and hamstring weakness when lying face down with legs flexed on thighs, but when he sat up on a table, with legs hanging down, good function of these muscles was demonstrable.

The testing of associated movements is also of great diagnostic import. Patient Z with hemiparesis not of organic origin showed weakness of the deltoid and pectorals on the involved side. However, when asked to extend his arms with palms together and forcibly resist separation, it was found that the resistance was equal bilaterally.

It has been noted here that use of the involved part is accompanied by an over-activity or over-dramatization of the part and contiguous structures, e.g., Patient W with hysterical foot drop, when attempting to dorsiflex the foot, bends his knee and raises his hip off the bed.

It has also been noted that the grotesque nature of gait disorders attributed to weakness of particular muscles disappears when patient is directed to walk on heels or toes, backward, sideways, with eyes open or closed, i.e., in a manner in which he is not accustomed to walk.

In many instances of paralysis of the hands diagnosed as peripheral neuritis or neuroma, an attitude of rigidity is assumed on attempt to close the fist. Careful palpation of the forearm during such attempted motion reveals good contraction of all the muscles including the extensors; every joint of hand and wrist is fixed. When such cases of paralysis are associated with gunshot wound or other injury to the bones of the wrist joint the paralysis is ascribed to the trauma. A simple neurologic fact would obviate such mistaken diagnosis: The power for finger flexion arises in the upper part of the forearm (because the nerve enters these muscles high).

To summarize, muscle analysis points the disparity between the physiology and anatomy of muscle on the one hand and the experientially assumed functions as manifested by hysterical somatization on the other hand. When carefully carried out, it clearly differentiates organic from functional muscular disorders.

Electrical testing need not be dwelt upon. It is performed for the sake of completeness, to assure the continuity of the nerve-muscle unit as revealed by transmission of the electrical impulse. At times this procedure is of definite therapeutic aid.

A most valuable adjunct diagnostically and therapeutically is narcosynthesis induced by either sodium pentothal (0.25–0.5 gms.) or sodium

amytol (0.25–0.5 gms.); amphetamine sulfate (0.01–0.02 gms.) is given with the sodium amytol. Intravenous injection is given slowly, watching the patient carefully for the desired state of narcosis. In some patients during this period, hysterical muscular disabilities miraculously clear up. Others obtain slow improvement after persuasion and several treatments. More resistive cases improve only after ventilation and release of emotionally laden material. An interesting example is that of a 27-year-old sergeant admitted to the neurosurgical service for peroneal nerve exploration and repair. This supposed neuropathology was complicated by a fractured and extensively burned lower extremity. Electrical studies were normal but some atrophy was present. It was felt, however, that he was suffering from hysterical paralysis. Barbiturate narcosynthesis confirmed this suspicion.

This procedure is not entirely without its dangers. Three patients became violently assaultive, requiring restraint, and on a few occasions marked paranoid reactions were released. No serious results followed, fortunately. The patients who have been accused of malingering in the past feel the procedure to be a direct attack on their persons and integrity, and consequently violence may result. However, by far the greater number of cases have benefited by this procedure and it has proved inestimably valuable in diagnosis and treatment.

All varieties of muscular involvement can occur. Flaccid paralysis is the most common type seen, but the spastic variety does occur and occasionally in very dramatic form. Patient V sustained soft tissue injury to right hand following which he developed spastic paralysis. The spasticity was so marked there was maceration between fingers, the nail of the little finger dug deeply into the index finger, and x-ray revealed changes in the joints of the fingers. Under barbiturate the spasticity changed to flaccidity. Eventually the paralysis disappeared entirely and he was sent back to duty.

Disability of back musculature is common and is either spastic, resulting in a rigid back and neck, or flaccid, resulting in a right angle bend at the hips.

This type of neurotic disorder responds well to therapy ordinarily. At best such therapy is superficial, however symptomatic. Relief is often given and sufficient adjustment made so that the patient can once more function fairly efficiently in his military environment or contribute to the war effort as a civilian.

In summary, it may be stated that early diagnosis is of prime importance for the successful treatment of these psychogenic muscular disabilities; that early diagnosis depends on careful history, muscle analysis, electrical testing, and barbiturate narcosis. It is essential that all the muscles concerned with the activity of a part involved be carefully tested.

BOOK NOTICES

Nature and Treatment of Mental Disorders. By DOM THOMAS VERNER MOORE, M.D. Price $4.00. Pp. 312. New York, Grune & Stratton, 1943.

Father Moore has presented his views on psychopathology and, in much greater detail, his techniques of therapy "by psychological analysis... free association and dream analysis ... family reorganization ... educational therapy ... bibliotherapy" and other methods. The techniques are highly individualized and eclectic but, on the whole, sound, despite the author's polemical preoccupation with certain features of psychoanalytic theory with which he does not agree. (K. A. M.)

War and Children: A Message to America. By ANNA FREUD and DOROTHY T. BURLINGHAM. Price $3.50. Pp. 191. New York, Medical War Books, 1943.

This book is a very important contribution not only to child psychology in wartime but also to child psychology itself. The different reactions of the child to air raids, the relationship to the mother, the damage done by sudden ill-guided separation from the mother and the conscious and unconscious conflicts of the mother are clearly discussed. The book points out the fact that air raids are traumatic not because they bring aggression to the child at an early age but because destruction in the world hinders the child in suppressing, repressing and sublimating his own aggressions. (E. R. G.)

Investigation of the Technique of Psychoanalysis. Edited by EDWARD GLOVER. Price 10s.6d. Pp. 188. London, Baillière, Tindall & Co., 1940.

Replies to questionnaires dealing with many technical points, both critical and trivial, in psychoanalytic treatment from 24 British psychoanalysts form the basis for this short discussion of technique. It appears that there is no unanimity of opinion regarding many moot points, and the author hopes his book will stimulate symposia and discussions leading to greater standardization of psychoanalytic technique. (R. P. K.)

The Collected Papers of Wilfred Trotter. Price $3.15. Pp. 194. London, Oxford University Press, 1941.

The son of Wilfred Trotter republishes in this small book ten essays which were originally prepared by his father as addresses to various medical bodies and which deal mainly with the philosophy of medicine. I recommend the collection highly; first, because of its good sense; secondly, because of the excellence of the writing; and, thirdly, because of the very stimulating final chapter. (K. A. M.)

The Neuroses in War. Edited by EMANUEL MILLER. Price $2.50. Pp. 250. New York, Macmillan Co., 1940.

Eleven British psychiatrists, all with dynamic viewpoints, cover the field of war neuroses from World War I to the present war experiences outlining

clearly the great advances made since 1914–18. There are several valuable chapters on treatment—hypnoanalysis being especially well discussed. This is essential reading for all psychiatrists and recommended reading for all physicians. (R. P. K.)

Mental Illness: A Guide for the Family. By EDITH M. STERN with the collaboration of SAMUEL W. HAMILTON. Price $1.00. Pp. 134. New York, The Commonwealth Fund, 1942.

A long needed little book of advice for the relatives of mentally ill patients has been carefully prepared and written with exactly the right spirit, the right content, the right style. Advice concerning problems prior to admission, during and subsequent to admission and subsequent to discharge are all taken up in short succinct chapters. A slight bias against private hospitals is inadvertently manifested in places, but in general the author is honest, clear, fair and straightforward. (K. A. M.)

Convulsive Seizures. By TRACY J. PUTNAM. Price $2.00. Pp. 168. Philadelphia, J. B. Lippincott Co., 1943.

As a sound, scientific and well written manual presenting the medical facts and commonly accepted theories about convulsive disorders, this book should be of great value to patients, their families and friends. It is not a manual of home therapy but is so written that it will supplement the attending physician's advice with general information. The book has a comparable function to that of Stern's *Mental Illness*, and the various diabetic manuals, which have proved their value when placed in the hands of a patient's family. (D. L.)

Methods of Treatment in Post-Encephalitic Parkinsonism. By HENRY D. VON WITZLEBEN. Price $2.75. Pp. 164. New York, Grune & Stratton, Inc., 1942.

This is a very useful monograph on the problem of post-encephalitic Parkinsonism. The author discusses differential diagnosis, many forms of therapy, including chemotherapy, serum and vaccine therapy, surgical, fever and Roentgen therapy as well as treatment with drugs other than the alkaloids. Particularly stressed is the "Bulgarian Treatment" which the author believes to be superior to any other alkaloid, including Rabellon. Physiotherapy is likewise stressed. There is a very good bibliography. (M. G.)

The Subnormal Adolescent Girl. By THEODORA M. ABEL and ELAINE F. KINDER. Price $2.50. Pp. 215. New York, Columbia University Press, 1942.

This is perhaps the first writing on the feebleminded to arouse interest and enthusiasm in persons who have done research in the problems of the feebleminded. The approach and techniques of modern psychology are used to derive conclusions. A warm human understanding is shown in characterizing the subnormal adolescent girl. The uniqueness and psychological soundness of this volume recommend it to all who may come in contact with subnormal persons. (D. R.)

Central Autonomic Regulations in Health and Disease. By HEYMEN R. MILLE. Price $5.50. Pp. 430. New York, Grune & Stratton, Inc., 1942.

That psychological conflict can lead to somatic disease by way of the autonomic nervous system implies the existence of central autonomic regulation in the higher nervous centers. In view of recent erroneous ideas about the hypothalamus as an initiator of emotions it is especially gratifying to see Doctor Miller's emphasis on the part played by the cortex as well as that of lower centers and his avoidance of the error of neglecting the psychological aspect of emotion. The book is an excellent, well documented account of our present state of knowledge of both the physiology and pathology of central autonomic function, a field of medicine which is becoming of growing clinical importance. There is a very good chapter on the anatomy of the hypothalamus. For clinical use the book is undoubtedly the best in its field. (M. G.)

Nervousness, Indigestion and Pain. By WALTER C. ALVAREZ, M.D. Price $5.00. Pp. 488. New York, Harper & Brothers, 1943.

Walter Alvarez has here contributed another addition to the recently begun series of books on psychosomatic medicine. It is characterized by his ingenious shrewdness of observation, interpretation and clinical management. The material is not labeled psychiatric or psychosomatic, but it is both. The average physician who reads it would double his efficacy by putting its principles into practice. (K. A. M.)

America's Last King. By MANFRED S. GUTTMACHER, M.D. Price $3.50. Pp. 426. New York, Charles Scribner's Sons, 1941.

This excellent case study of the five attacks of cyclothymic illness in George III is a cherished addition to the library of the psychiatrist. With a great deal of effort, the author obtained access to letters, records, and nurses' notes which he has assembled with great pains. American psychiatrists, in particular, should read the book and get a new notion of the good qualities of a poor, sick King whose compulsions (rather than malice or hate) led to his provocative mismanagement of the American colonies. (K. A. M.)

Psychology Through Literature. By CAROLINE SHRODES, JUSTINE VAN GUNDY and RICHARD W. HUSBAND. Price $3.50. Pp. 389. New York, Oxford University Press, 1943.

Freud himself acknowledged repeatedly that the poets and artists knew about the unconscious long before the scientists did. In this book fifty odd selections from literature illustrating psychological and psychiatric and psychoanalytical tenets are presented, and the psychological relevance of some two hundred other articles and books is briefly stated in a bibliography. Some of the selections are excellent. (K. A. M.)